PHYSICIAN/CLINICIAN STATEMENT OF CAPABILITIES

PLEASE PRINT THE FANF INDIVIDUAL'S NAME, RECIPIENT IDENTIFICATION (RID) NUMBER, & CASE NUMBER

FANF Individual

RID #

Case #

FOR DEPT USE ONLY - CHECK IF FOR A HARDSHIP APPLICATION ☐

TO: ☐ **PHYSICIAN or** ☐ **CLINICIAN**

NAME:

ADDRESS:

PHONE:

RETURN TO:

MEDICAL EXEMPTION UNIT (MEU)
DIVISION OF FAMILY ASSISTANCE, DHHS
129 PLEASANT STREET, BROWN BLDG
CONCORD, NH 03301-3857
PHONE: 1-800-852-3345 EXT. 9511
FAX: 271-4637

YOU ARE RECEIVING THIS FORM BECAUSE YOU ARE THE HEALTHCARE PROVIDER FOR THE INDIVIDUAL IDENTIFIED ABOVE.

Financial Assistance for Needy Families (FANF) program recipients are required to participate in activities that help prepare them for self-sustaining, unsubsidized employment.

The individual named above reports that they are either limited or unable to participate in activities due to a medical and/or psychological condition. We need your professional assessment to help us determine this individual's abilities and limitations with regard to preparatory and work-related activities.

The attached form has 2 sections. Please complete and return the appropriate sections:

Section 1 – Treating patient's physical condition.

Section 2 – Treating patient's psychological condition.

Your patient should provide you with a signed *Authorization for Release of Protected Health Information* (DFA Form 752A) providing permission to release the information contained in this form to DHHS. Please fax or mail this completed form directly to the Medical Exemption Unit (MEU) using the contact information above. If you have any questions, please call the MEU at the number listed above.

Work-Related and Work Preparation Activities

There are many work-related activities offered to individuals in the FANF work program. FANF recipients can participate in activities adapted to meet the individual's needs and abilities. Activities include:

- **Work-Related Activities -** This may include paid or unpaid work, or structured, supervised work activities that provide the individual the opportunity to experience and acquire the general workplace behaviors, attitudes, skills, and knowledge necessary to obtain and retain paid employment.
- **Education or Training -** This may include basic or adult education, ESL, or other education or training programs that promote employability.
- **Barrier Resolution** – This may include counseling or other services designed to minimize or resolve a personal issue or other barriers to employment.

Signatures accepted by MD, ARNP, PA, LICSW, LCMHC, and PH.D. Certified nurse-midwife for pregnancy conditions only. All others must obtain corroborative signatures.

Payment of any separate charge for completing this form is the responsibility of the patient. DHHS will not pay charges solely for the completion of medical forms.

SECTION 1 - PHYSICAL CAPABILITIES

(Complete if treating a physical condition)

Patient's name: _____

Diagnosis: _____

Date of onset of condition: _____ **Prognosis (in months):** _____

Comments: _____

Please assess the patient's ability to participate in the following activities by circling the appropriate answer:

YES	**NO**	Can perform sedentary activities, including frequent sitting or occasional standing/walking such as classroom situations, desk work, counseling sessions or other appointments.
YES	**NO**	Can perform light work activities. This includes frequent walking, lifting of objects weighing 10 pounds or the operation of simple equipment.
YES	**NO**	Can perform medium work activities. This includes frequent reaching, bending, or lifting of objects weighing 25 pounds and activities involving fine manual dexterity or coordination.
YES	**NO**	Can perform heavy work. This includes frequent physical exertion in a taxing work position such as lifting and dragging heavy objects weighing 50 lbs or more.

With normal breaks, please indicate the maximum daily time the patient can:

Activities	None	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours	7 hours	8+ hours
Sit									
Stand									
Walk									

Please indicate if added breaks or change of position are needed: _____

Patient can:	Never 0%	Occasionally 33%	Frequently 66%	Repetitively 100%
Lift				
10 pounds (lbs.)				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
Carry				
10 pounds (lbs.)				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
Kneel				
Bend (from waist)				
Crouch (at legs & spine)				
Climb Stairs				
Climb Ladders/ Scaffolds				
Crawl				
Reach (above shoulder level)				
Twist (at waist)				

Patient can:	Never 0%	Occasionally 33%	Frequently 66%	Repetitively 100%
Use right hand:				
Simple grasping				
Fine manipulation				
Pushing & pulling				
Use left hand:				
Simple grasping				
Fine manipulation				
Pushing & pulling				
Use right foot				
Use left foot				

Check any of the following conditions that the patient should AVOID due to their condition:

☐ Outside	☐ Extreme Cold	☐ Extreme Heat	☐ Wet or Humid	☐ Heights
☐ Fumes or Dust	☐ Hazardous Areas	☐ Noise/Vibrations	☐ OutsideTerrain	☐ Driving
☐ Hard Floors	☐ Other:			

Medications prescribed that affect capabilities: _____

_____

Other comments or accommodations: _____

_____

_____

Is the patient capable of participating in work-related activities at this time?

☐ **YES or** ☐ **NO**

If YES, indicate the number of hours the patient can participate a week:

☐ **10 – 19 hours** ☐ **20 – 25 hours**
☐ **26 – 30 hours** ☐ **31 – 40 hours**

If there are restrictions, how long should these restrictions be in place?
(in months) _____

If awaiting further results, how long until the evaluation is complete? _____

Please include a copy of the patient's treatment plan and/or other supporting medical information.

_____ _____ _____
Physician/Clinician's Signature **Date** **Phone #**

_____ _____
Physician/Clinician's Printed Name **Medical Specialty**

SECTION 2 - PSYCHOLOGICAL CAPACITIES

(Complete if treating client's psychological condition)

Patient's name: _____

Diagnosis: _____

Date of onset of condition: _____ **Prognosis (in months):** _____

Comments: _____

For each activity shown below, rate the individual's ability to perform the activity using the following rating terms:

None	No Deficit; Ability is not limited
Mild	Individual can perform the activity satisfactorily most of the time
Moderate	Individual can perform the activity satisfactorily some of the time
Marked	Individual has no useful ability to function

Activity	**None**	**Mild**	**Moderate**	**Marked**
Interacts appropriately with others				
Maintains socially acceptable behavior				
Asks questions or requests assistance when necessary				
Adheres to basic standards of neatness and hygiene				
Aware of normal hazards and takes precautions				
Remembers locations and work-like procedures				
Understands and remembers short, simple instructions				
Maintains attention for extended periods				
Sustains routine without frequent supervision				
Makes simple work-related decisions				
Performs at a consistent pace				
Driving				
Other:				

Any medications prescribed that affect capabilities? _____

Other comments or accommodations: _____

Is the patient capable of participating in work-related activities at this time?

☐ **YES** ☐ **NO**

If YES, indicate the number of hours the patient can participate a week:

☐ **10 – 19 hours** ☐ **20 – 25 hours**

☐ **26 – 30 hours** ☐ **31 – 40 hours**

If there are restrictions, how long should these restrictions be in place? (in months) _____

If awaiting further results, how long until the evaluation is complete? _____

Please include a copy of the patient's treatment plan and/or other supporting medical information.

Physician/Clinician's Signature	**Date**	**Phone #**

Physician/Clinician's Printed Name	**Medical Specialty**